UTAH-DOH-BES
Form 121 10/02

REQUEST FOR MEDICAID DISABILITY DECISION

TO BE COMPLETED BY WORKER

PACMIS CASE # _____

CLIENT NAME _____ AGE _____ CLIENT ID# _____

MEDICAID APPLICATION DATE _____ CLIENT'S ALLEGED ONSET DATE _____

REQUEST RETROACTIVE ELIGIBILITY TO INCLUDE MONTHS OF_____

HAS CLIENT APPLIED FOR SOCIAL SECURITY DISABILITY BENEFITS? ☐ YES ☐ NO. DECISION/DATE: _____

HAS CLIENT BEEN RECEIVING PCN SERVICES? ☐ YES ☐ NO BEGINNING DATE _____

DWS / BES OFFICE _____ TEAM _____ WORKER _____ PHONE _____

REVIEW COMMITTEE DECISION

☐ WITHHELD (See Rationale Below)

Decision ☐ ALLOWED START DATE _____

☐ DENIED (See Rationale Below)

Diagnosis Primary:_____
Secondary:_____

RATIONALE _____
_____
_____
_____

REVIEWER SIGNATURE _____ DATE _____

SECOND REVIEWER (If applicable) _____
_____
_____
_____

REVIEWER SIGNATURE _____ DATE _____

FOR ALLOWANCES: Suspense Date for Medical Review ☐ 6 Months ☐ 12 Months
☐ Other ☐ Review Not Indicated

ADDITIONAL REMARKS/EVIDENCE _____
_____
_____